

Perianal Fistülü Taklit Eden Pilonidal Sinüs ve Limberg Flep Yöntemiyle Tedavisi: Olgu Sunumu

Pilonidal Sinus Mimicking Perianal Fistula and Successful Treatment with Limberg Flap: Report of a Case

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ABSTRACT

Pilonidal sinus is known as simple condition which has a high incidence. But it may become as a chronic and complicated disease that typically occurs in the intergluteal region. In some cases the disease may show extension to perianal region in caudal course and can present with secondary perianal openings. These complex cases with secondary openings may create problems in diagnosis and treatment when the secondary openings are close to the anus. In this case a single-stage surgical procedure for treatment of sacrococcygeal pilonidal disease with secondary perianal opening was described.

Key words: Pilonidal sinus, Perianal fistula, Limberg flap

ÖZET

Pilonidal sinüs sık görülen, basit bir hastalık olarak kabul edilir. Fakat sıklıkla intergluteal bölgede, kronik ve komplike bir hastalığa dönüşebilir. Bazı durumlarda perianal bölgeye kadar uzanabilir ve bu bölgeye açılan sekonder sinüslerle karşımıza çıkabilir. Bu kompleks vakalarda perianal bölgeye açılan sinüsler anüse çok yakınsa tanı ve tedavide güçlüğü neden olabilir. Bu yazıda perianal bölgeye uzanan pilonidal sinüs hastalığının tek evreli cerrahi tedavisi anlatılmıştır.

Anahtar kelimeler: Pilonidal sinüs, Perianal fistül, Limberg flep

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Introduction

Pilonidal sinus disease is a chronic inflammatory condition that often affects young adults. Presentation of pilonidal disease may vary from limited involvement of the natal cleft to perianal extension with secondary perianal opening. In this presentation, pilonidal disease mimicks fistula in-ano and these cases need special approach. Modifications of flap techniques were reported for the treatment of these complex cases.¹

In this case a single-stage surgical procedure for treatment of sacrococcygeal pilonidal disease with secondary perianal opening treated with Limberg flap technique was described.

Case Presentation

A 32 year old man was admitted to hospital with burning and sero-purulent secretion in the perianal region which had been present for 9 years. In the physical examination, there was an asymptomatic pit located in the sacrococcygeal region and also there was a chronic sinus with sero-purulent secretion located near 2 cm to the anus in the left side (Figure 1). There was three times abscess and drainage history. During 9-year period, there had been no complete healing in the wound near the anus and sero-purulent secretion had been continued. The patient's brother had pilonidal sinus disease in his past medical history. The anoscopic examination in the operating room revealed that there was no internal opening in the anal canal. The body mass index of patient was 28.4 kg/m².

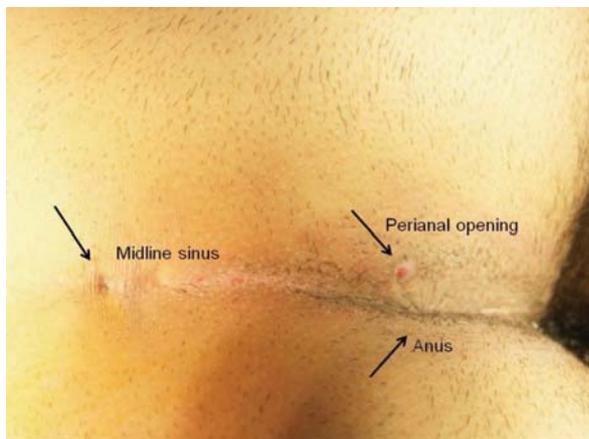


Fig. 1. Appearance of midline sinus, perianal opening and the anus.

A piece of wet gauze was inserted in to the anal canal. The methylene blue was given from the pit in the sacrococcygeal region and indicated the fistula between the sinuses located in the sacrococcygeal and perianal region. The gauze was removed and there was no blue dye. After the preparation of the skin with povidone iodine solution, the skin incision was deepened to the presacral fascia. Tissue was removed en bloc as rhomboid excision. A surgical instrument was inserted through the perianal sinus and the fistula tract was demonstrated (Figure 2). After the rhomboid excision, the left inferior edge was enlarged to perianal sinus and the tract connected with the perianal sinus was excised (Figure 2).



Fig. 2. The fistula tract was demonstrated. The incision was enlarged and the tract connected with the perianal sinus was excised.

The flap was prepared. Between gluteus fascia of the flap and presacral fascia, 2/0 vicryl sutures were used. The skin was closed with 3/0 prolene suture. A drain was left and the patient was discharged on postoperative day -2. The drain was removed when the drainage had decreased to less than 20 ml/day. The antibiotic treatment was administered with ampicillin/sulbactam for 5 days. The sutures were removed 10 days after the surgery. No complication in wound healing was observed in the early postoperative period. The patient was seen in clinic on postoperative days 15, 30 and 6 months later after operation. There was no recurrence in the 6 months period (Figure 3).



Fig. 3. Appearance of the wound 6 months after the operation.

Discussion

Pilonidal disease is a difficult problem for the patient and the surgeon. The data derived from the literature indicates that there are limited numbers of articles mentioning from pilonidal sinus mimicking perianal fistula and treatment modalities for this situation.^{1,2} The pilonidal disease may show extension to perianal region. Although pilonidal sinus disease has characteristic appearance, this situation may result difficulties in distinguishing between perianal fistula and pilonidal sinus disease. The fistula originating from complicated pilonidal disease may show extension subcutaneously but anal fistulas have connections within anal canal or within the rectum. It was reported that 7% of the pilonidal sinus may extend caudally perianal region and may

present as perianal fistula.³ Taylor *et al.*⁴ reported the differences of pilonidal sinus and perianal fistula diseases in magnetic resonance (MR) imaging findings. According to their results the natal cleft sepsis may reach the subcutaneous tissues overlying the coccyx and the sacrum, but the absence of intersphincteric sepsis or enteric openings is suggestive of pilonidal sinus disease rather than perianal fistula. In our case MR was not planned since it doesn't exist in rural area hospitals. The diagnosis was made with methylene blue injection. It demonstrated the subcutaneous connection of the fistula tract to the perianal region and the absence of fistula in ano. In previous studies pilonidal sinus which extends to perianal region has not been defined clearly. For that reason this situation was discussed such as pilonidal sinus simulating rectal fistula, pilonidal sinus with multiple openings, complex or complicated pilonidal disease. There is currently no certain consensus on the optimal treatment technique of this condition. Kulacoglu *et al.*¹ reported fistulectomy plus Karydakias flap for sacrococcygeal pilonidal disease with secondary perianal opening. Akinci *et al.*⁵ suggested limited separate elliptical excision with primary closure for pilonidal disease with paramedian fistula. According to the authors who treated pilonidal sinus with secondary perianal openings, this situation should be accepted as classical pilonidal disease and it can be treated by total excision and flap techniques.^{1,6}

In this case a single-stage surgical procedure for treatment of sacrococcygeal pilonidal disease with secondary perianal opening treated with Limberg flap technique was described.

Kaynaklar

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